Health planning in India

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**Health Planning**

**Definition:** A systematic method of trying to attain explicit objectives for the future through efficient and appropriate use of resources, available now and in the future.

**Concepts of Definition:**

1. Objectives: Where are we going?
2. Resource: With what?
3. Efficient & appropriate implementation :How?
4. Future : When?
5. Explicitness, systematic & method : Degree of formalization about process.

**Hart Definition**: The determination in advance of a line of action by which certain results are to be achieved.

**Types of health planning:**

1. **Activity planning:** setting of monitorable timetables and schedules for implementation of pre-set activities.
2. **Allocative planning**: the decision on how resources should be spent. (Resources are always scarce, though gap much less in developed countries)

**Principles in planning:**

* **Congruity in social planning**: any one or a set of components cannot be altered without changes in other parts of the social whole
* **Selective Deployment of Resources**: imbalance between needs and resources; schedule priorities
* **Structural adequacy**: apart from content of the plan, necessary to design its organization and methodology of execution.

**Steps in planning:**

## Study in totality and analysis of health situation

## Identification of major problems

## Prioritization

## Definition of selected problems

## Identification of feasible interventions

## Examination of available resources

## Definition of objectives

## Programme planning

## 9. Monitoring and feedback

## 10. Evaluation

## Prioritization

## Magnitude of problem

## Risk of mortality

## Morbidity

## Frequency, nature and severity of complication

## Residual damage

## Potential risk of epidemics

## Transcendence

## Social stigma

## Collateral benefits

## Technical feasibility

## Vulnerability

## Administrative feasibility

## Economic consideration

## Political consideration

**Advantages of Planning**.

1. Attention to the objectives
2. Minimizing uncertainties
3. Better utilization of Resources
4. Economy in operations:
5. Better coordination
6. Encourages innovations and creativity
7. Management by exception possible
8. Facilitates control
9. Facilitates delegation

**Limitations of Planning**.

1. Needs reliable data (unless which planning loses its value)
2. Time consuming process
3. Expensive
4. External factors may reduce utility (like economical, social, technological or legal)
5. Sudden emergencies
6. Resistance to change

**Development of health services and health legislation in India**

**3000-1500 B.C:** Mohenjodaro & Harappa (Indus valley civilization)- planned cities

**1400-1000 B.C:** Vedas & Upanishads Ayurveda

**600 B.C. – 600 A.D:** Budhism and Jainism,

Taxila and Nalanda University

**650-1850 A.D:** Islamic medicine (Unani system),

East India company (Western Medicine)

**1825:** Quarantine Act

**1835:** Calcutta Medical college

**1859**: Royal commission - ?? Unsatisfactory health condition,

Recommended **“Commission of Public Health” in each presidency**

**1869:** Sanitary Commissioner and Statistical Officer

1873: Bengal Birth And Death Registration Act

**1885**: Local Self Government. Act

Public Health Services their responsibility, without financial assistance

**1886-1888:** Medical Act

Sanitary Commissioner and Dir.Gen IMS merged

**1896:** **Plague commission**

Births, deaths and marriages Registration Act

**1903:** King’s institute of Preventive Medicine founded as a provincial public health laboratory for Madras

**1909:** Central malaria bureau (NICD)

**1911:** Indian Research Fund Association (ICMR)

**1929-1930:** Extend public health to rural areas

Every ‘thana’ circle – Sanitary inspector and Medicine carrier

**1933:** All India Instt. Of Hygiene and Public Health, Calcutta

**1939:** Madras Public health Act – 1st such

**1943-1946:** **Bhore Committee**

**Bhore Committee**

* Also k/as ‘**The Health Survey and Development Committee’**
* Appointed in1943; report in 1946
* Chairperson: **Sir Joseph Bhore**

**OBSERVATIONS:**

1. Health status poor
   * CDR = 22.4/1000
   * IMR = 162/1000 live births
   * MMR = 20/1000 live births
   * Life Expectancy at birth = 27 years
   * High incidence of CDs like cholera, small pox, malaria
   * Malnutrition, poor sanitation
2. Most of the problems were preventable, i.e. prevention was a good investment with high returns
3. Health and development were interrelated; cooperation with other sectors was needed

**Recommendations:**

1. Short term plan (for two 5 year periods)

* PHUs :- for 40,000 population
  + 2 MOs, 5 Nurses, 4 Midwives, 4 trained dais, 2 sanitary inspectors and supportive staff, - 4 beds
* 30 bedded hospital : - for 4 PHUs
  + double by 10th year
* Sec.HC with 200 beds (500 by 10th year)
* Health committee in each village (sanitation and control of infections)

1. Long term plan (for next 30 to 40 years)
2. 3 tier health care delivery system

* 1st tier : primary health care unit
  + 10,000 to 20,000 population
  + 75 beds
  + staff of 6 MOs, 6 PHNs, 2 sanitary inspectors, 2 health assistants
  + curative and preventive services
  + through clinic and domiciliary services
* 2nd Tier : Regional Health Unit
  + 550 beds
  + 15 to 25 PHUs
  + 140 doctors, no. of PHN, a Sanitary inspector, asstt. Public health engineer
* 3rd tier :District Health Unit
  + 3 million population
  + 2500 bedded hospital
  + for 3 to 5 Regional Health Units

1. Gave the concept of Comprehensive Health Care i.e.

* Promotive, preventive, curative and rehabilitative services all together as a package
* Access to all, irrespective of their ability to pay (equity)
* At their doorsteps (close to client)
* Cooperation b/w community and Health care providers (community participation)
* Healthy environment at workplace and at home (occupational health)
* Especially for under privileged and down trodden sections of society (women, children, and aged)

1. Similar to the ‘Beveridge Report’ of UK-

* “No individual should be unable to secure adequate medical care because of inability to pay for it.”
* Also advised on changes in medical education to suit community needs, i.e. upgrading of licentiate physician’s training to full medical graduation
* Needed 2,34,000 doctors for that population; even today have slightly more than half that number

**1952: Community development programme**

**Community development programme**

* Launched on 2nd October 1952.
* Each district divided into BLOCKS for development
* 5400 blocks - 66,000 population
* - 10 villages
* Block Development Officer
* Extension Officers – agriculture, social education, animal husbandry, programmes for women and children etc.
* Each block to deal with the problems of
  + poverty
  + ignorance
  + ill health
* 1st five years – intensive phase – Rs.12 lakhs / block, next five years – post intensive phase – Rs. 5 lakhs
* At the district level – District Development Board (Collector as chairperson)

For health purposes :

The Central Council of Health – 1st meeting in 1953

* + 1 PHC for each Community Development Block
  + For promotive, preventive and curative services
  + Health education to be integral part of health activities
  + Sub Centre for distant areas
* PHCs to provide Basic Health Services
  + Medical care - control of CDs
  + MCH - nutrition
  + Health education - school health
  + Environmental sanitation
  + Collection of vital statistics
* PHC
  + 4 to 6 beds
  + population of 60 to 80 thousand
* At sub-centre trained mid-wife to look after MCH services

**1959-61:** **The Mudaliar Committee**

**Mudaliar Committee**

* Also k/as the ‘**Health Survey and Planning Committee’**
* Appointed in 1959; report in 1961
* Chairperson : **Dr.AL Mudaliar**

1. **OBSERVATIONS:**
2. Existing PHCs – unsatisfactory; insufficient resources, facilities, personnel
3. Outlay for health in the 3rd five year plan not sufficient (Rs. 342 crores i.e. 4.3% for health programmes)
4. **RECOMMENDATIONS:**

* Each PHC should serve a population of not more than 40,000
* Strengthen the existing PHCs before establishing new ones.
* Strengthen the District hospitals to be effective referral centres
* Establish regional directorates within the states : Regional Deputy / Assistant Directors to supervise 2 to 3 DHOs – link between district and state level organizations.
* Create an All India Health Services (similar to IAS) to integrate medical and health services.
* Train auxiliaries to help doctors
* **Train paramedical personnel in other diseases in order to make them multi-purpose personnel**
* Provide to the people the minimum needs for health , like housing, safe drinking water, drainage, food, health care etc. within as short a time frame as possible.

**1961:** Advent of Panchayati Raj

**Advent of Panchayati Raj**

* Panchayat act in 1961
* District administration re-organised into 3 tier Panchayati Raj (self governing autonomous bodies formed at different levels)
* **At the village level**
  + population 1000 to 10,000: Gram panchayat
  + population 10,000 to 30,000: Nagar Panchayat
  + 15 to 30 elected members, with Sarpanch and

Upasarpanch

* + for health: village health committee
* **At the Block level:** Panchayat Samiti
  + members: all village sarpanches, representatives of women, SCs, STs, Co-operative societies,MLAs and MPs residing in that area
  + BDO is Secretary
  + Chairman and Vice-chairman is elected
* **At the District level:** Zilla Parishad
  + Members: heads of PSs, representatives of women, SCs, STs, Co-operative societies, MLAs and MPs residing in that area
  + District Development and planning Officer is Secretary
  + President and Vice President are elected
  + ZP is directly responsible to the State Assembly
  + for health : District Health Office
* The 73rd Amendment Act 1992
  + PRI till now under the Directive Principles of State Policy – non-justiciable
* Now given legal sanction
  + adequate administrative and financial powers
  + mandatory to hold elections within 6 months of dissolution
  + reservations for women, SCs, STs
* Will help in increasing people’s participation for health

**1964-67:** The Jungalwalla Committee

**The Jungalwalla Committee**

* Also k/as “**Committee on Integration of Health services**”
* Appointed in 1964; report in 1967
* Chairperson: **Dr. N Jungalwalla** (Director of National Institute of Health Administration and Education)

1. **RECOMMENDATIONS:**

Integrated Health Services

1. Unified approach to all problems
2. Public health programmes and medical care should be under charge of a single administrator (below district level)
3. For all programmes there should be
   * uniform cadre
   * common seniority
   * recognition of extra qualifications
   * equal pay for equal work
   * special pay for specialized work
   * no private practice
   * good service conditions

Benefits of Integrated Health Services

1. Preventive services more acceptable if curative services pave the way
2. Total health cared for in a single package
3. Balance between curative and preventive services (normally curative services eat away the resources)
4. Bigger staff and budget; can compete with other govt. departments
5. Curative and preventive both interdependent

**The result:**

* At district level only one district level officer (CMO / CMO&H)
* At block level Dy. CMO
* In MS, Civil Surgeon (hospitals, urban)
  + - DHO (PHC, rural)

**1972-73: The Kartar Singh Committee**

**Kartar Singh Committee**

* Also k/as ‘**Committee on Multi purpose workers under Health and Family Planning’**
* Appointed in 1972; report in 1973
* Chairperson: **Shri Kartar Singh** (Addl. Secy. MoHFP)

**OBSERVATIONS:**

1. Many vertical programmes 🡪 many cadres of workers
2. Each has a population of 10,000 to 20,000 to cover
3. People complain of too many health workers coming and enquiring about their health
4. People complain that health workers do not give medicines

**RECOMMENDATIONS:**

Integrated Health Services

1. The ANM 🡪 Health Worker (F)
   * population of 3000 to 3500 (intensive area)
   * total population 10,000 (rest is twilight area; services available only on request)
   * area not more than 5 kms
   * to do
     + Family Planning & MCH
     + medical care
     + nutrition education
     + health education work
2. Basic Health worker (male) =Health worker Male
   * Vaccinators
   * Health Education Assistant
   * FP health assistant
   * population of 6000 to 7000

Duties:

* + Malaria
  + Small pox
  + Family Planning
  + Immunization
  + Environmental Sanitation
  + Nutrition Education
  + Control of Communicable Diseases
  + Health Education

1. Initially start in areas where
   1. small pox controlled
   2. malaria in maintenance phase
2. Initially start with workers from 4 programmes
   1. Malaria
   2. small pox
   3. trachoma
   4. family planning
3. One health worker male and female each for one sub centre (population 3 to 5 thousand)
4. Supervisors to act as Health Assistants (male and female) – one each for 3 to 4 male / female health workers respectively
5. One PHC to manage population of 50,000, i.e. about 16 sub centers each.
6. The MO of PHC to have overall charge of HWs and HAs
7. Detailed recommendations about the training requirements for
   1. in service workers
   2. newly employed workers

**1974-75:** The Srivastava Committee

**The Srivastava Committee**

* Also k/as the ‘**Group on Medical Education and Support Manpower**’
* Appointed in 1974; report in 1975
* Chairperson: **Dr. JB Srivastava**

**RECOMMENDATIONS:**

1. The concept of ‘ Community Participation’
2. A village level health worker – paraprofessional / semiprofessional
   1. from within the community
   2. act as link between community and PHC
   3. housewives, school teachers, dais, public functionaries
   4. no remuneration
   5. might not necessarily be multi-purpose
3. The health worker to act as a link between the village level worker and the PHC
   1. one HW for every 5000 population
   2. HW equipped to give simple specified remedies for day to day ailments
   3. one Health Assistant for every two HW
   4. HA to be based in a subcentre and not PHC
   5. HA to act as HW in own area with additional training
4. Good referral system.
5. A Medical and Health Education Commission on the lines of the UGC
6. One more Medical Officer at the PHC
7. More grants to the PHC for purchase

Formed a basis for launching of Rural Health Scheme in 1977

**Five year plans:**

* Planning is a continuous process
* Undertaken in periods of five years
* Conceived against a longer perspective
* Working groups constituted 🡪 approach paper
* Recommendations considered by planning commission
* First two plans set against a simple projection of economic growth over the next 30 years (1951-1981) and objectives based on recommendations of Bhore Committee
  1. **First Five year Plan: (1951-56)**

1. Preventive care in rural area through health units
2. Control of CDs, especially malaria
3. MCH
4. Drugs and equipment- self sufficiency
5. Water supply & sanitation
6. FP and population control
7. Education training & HE
   1. Second Five year Plan: (1956-61)

* Continuation of first plan
* Health services within the reach of all

1. Adequate institutional facilities for organizing health services
2. Technical manpower
3. Control of CDs
4. Environmental sanitation
5. FP
   1. Third 5-year plan (1961-66)

* Based on recommendations of Mudaliar Committee
* As first phase of 15 year programme (1961-76)
* Emphasis on increasing efficiency, FP, control of CDs

1. Establishment of one PHC / CD block
2. Drinking water in most villages
3. Completing malaria and small pox eradication
4. Further provision of training facilities for medical / health personnel
5. Fourth 5-year plan (1969-74): Fourth five-year plan postponed due to uncertain economic condition in the country

Annual plans (1966-69)

* 1. 4.7% of total annual budget spent on Health

Objectives:

1. Strengthening of PHCs, sub-div, and district hospitals
2. Integration of programs relating to control of CDs like TB, malaria, leprosy, trachoma and eradication of small pox
3. Training of health functionaries
4. Self sufficiency in manufacture of drugs and equipment
5. **Fifth Five-year plan: (1974-79)**

* Provision of health as major component of Minimum needs programme
  1. Expanding network of facilities
  2. Increasing accessibility in rural areas
  3. Correction of disparity between rural and urban areas
  4. Intensification of Nat. programs, esp. malaria and small pox
  5. Water supply; disposal of waste
  6. Improving quality of Health services by trained personnel
  7. Rural orientation to medics and paramedics

1. **Sixth 5-year plan: (1980-85)**

* Based on Srivastava Committee report
* Intensification of minimum need programme

1. Better health services for rural poor
2. A community based programme of health care
3. No linear expansion of curative services in urban areas
4. Rural infrastructure strengthened to achieve HFA-2000
5. **Seventh Five Year Plans:(1985-1990)** 
   1. NRR = 1 by 2006 to 2011
   2. Focus on reversible methods
   3. Over reporting to achieve targets (ORG,NFHS)
6. **Eighth Five year Plan: (1992-1997)**
   1. NRR = 1 by 2011 to 2016
   2. National Population policy
7. **Ninth 5-year plan:(1997-2002)**

New initiatives:

* 1. Horizontal integration of vertical programs
  2. Disease surveillance and response mechanism
  3. Integrated NCD control program
  4. Health Impact assessment as part of environmental impact assessment
  5. Management for disaster, emergency, accident, trauma care
  6. Improve HMIS

1. **Tenth 5-year plan: (2002-2007)**
   1. Implement the recommendations of 7th, 8th and 9th plans
   2. Villages/areas under PHD etc. defined using GIS to improve access
   3. Gaps in manpower to be met with re-orientation, skill up gradation and redeployment
   4. Increase public-private-voluntary sector collaboration
   5. Quality and accountability in health care to ensure improvement in health indices and affordable health care for all
   6. Integrating ISM&H in mainstream
   7. CME and skill up-gradation for all medical personnel
   8. Communicable diseases
      1. 25% reduction in malaria by 2007
      2. elimination of kalaazar by 2010
      3. expansion of RNTCP to cover entire country
      4. completing horizontal integration of NLEP by 2007
   9. NCDs
      1. clear backlog of cataract blindness by performing 4.5 million operations/year
      2. strengthening of emergency and casualty services
      3. disaster management
      4. establish norms for work environment
   10. Financing: those BPL ready access to subsidized services; those above PL pay
2. **Eleventh Five year plan:**